Provider Newsletter

Amerigroup
An Anthem Company

Amerigroup Washington, Inc.
https://providers.amerigroup.com/WA
Medicaid providers: 1-800-454-3730
Medicare providers: 1-866-805-4589

November 2020

Want to receive the *Provider Newsletter* via email?
Click here to provide/update your email address.

Table of Contents

COVID-19 information from Amerigroup Washington, Inc.

Amerigroup is closely monitoring COVID-19 developments and how the novel coronavirus will impact our customers and provider partners. Our clinical team is actively monitoring external queries and reports from the Centers for Disease Control and Prevention (CDC) and the Washington State Department of Health to help us determine what action is necessary on our part. Amerigroup will continue to follow Washington State Department of Health guidance policies.

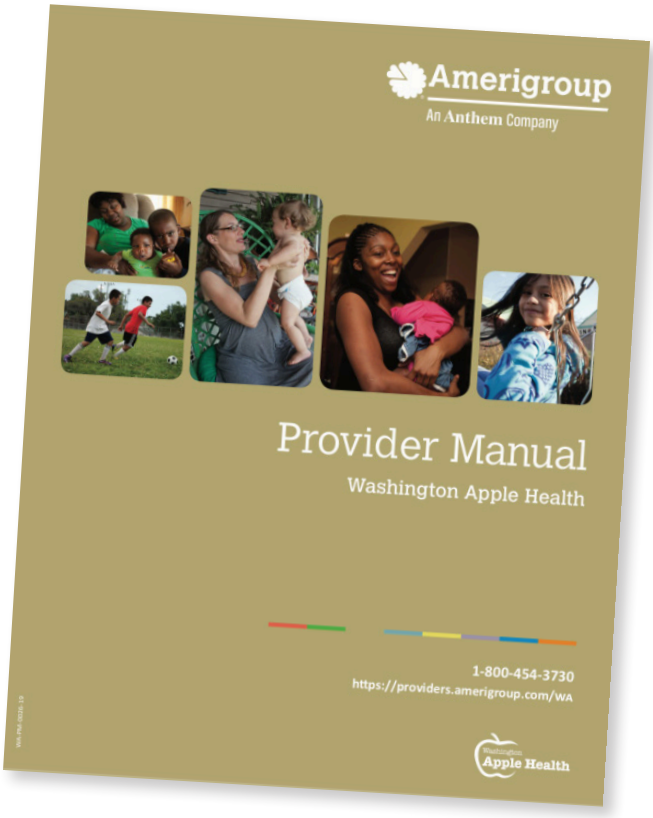
For additional information, reference our **website**.

WAPEC-2237-20

Update to the provider manual

Amerigroup Washington, Inc. is excited to announce an update to the *Medicaid Provider Manual*.

Our updated *Medicaid Provider Manual* will be available for use and distribution on or before January 1, 2021. You can obtain a copy of the provider manual by visiting our provider website at **https://providers.amerigroup.com/WA**, selecting **Provider Manuals and Guides** and then selecting **Medicaid Provider Manual**.



The Medicaid Provider Manual covers many different topics and all are important for you to review. Some of the key areas are:

- Integrated managed care (IMC)
- Claim submissions and encounters procedures
- Provider claim payment disputes and appeals procedures
- Prior authorizations and prior notification processes
- Support and training for providers
- Electronic funds transfer (EFT)/electronic remittance advice (ERA) enrollment
- Value-added benefits

WA-NL-0462-20

Digital transactions cut administrative tasks in half

Introducing the Amerigroup Washington, Inc. *Provider Digital Engagement Supplement* to the provider manual

Using our secure provider portal or EDI submissions (via Availity*), administrative tasks can be reduced by more than 50% when filing claims with or without attachments, checking statuses, verifying eligibility and benefits, and when submitting prior authorizations electronically. In addition, it could not be easier. Through self-service functions, you can accomplish digital transactions all at one time, all in one place. If you are not already registered, just go **here** for EDI or **here** for the secure provider portal (Availity).

Get payments faster

By eliminating paper checks, electronic funds transfer (EFT) is a digital payment solution that deposits payments directly into your account. It is safe, secure and will deliver payments to you faster. Electronic remittance advice (ERA) is completely searchable and downloadable from the Availity Portal or the *EDI 835* remittance, which meets all *HIPAA* mandates — eliminating the need for paper remittances.

Member ID cards go digital

Members who are transitioning to digital member ID cards will find it is easier for them and you. The ID card is easily emailed directly to you for file upload, eliminating the need to scan or print. In addition, the new digital member ID card can be directly accessed through the secure provider portal via Availity. Providers should begin accepting the digital member ID cards when presented by the member.

Amerigroup makes going digital easy with the *Provider Digital Engagement Supplement*

From our digital member ID cards, EDI transactions, application programming interfaces and direct data entry, we cover everything you need to know in the Provider Digital Engagement Supplement to the provider manual, available by going to **https://provider.amerigroup.com/washington-provider/resources/training-academy**, and on the secure **Availity Portal.** The supplement outlines our provider expectations, processes and self-service tools across all electronic channels Medicaid and Medicare, including medical, dental and vision benefits.

The *Provider Digital Engagement Supplement* to the provider manual is another example of how Amerigroup is using digital technology to improve the health care experience. We are asking providers to go digital with Amerigroup no later than January 1, 2021, so we can realize our mutual goals of reducing administrative burden and increasing provider satisfaction and collaboration. Read the *Provider Digital Engagement Supplement* now by going to **https://provider.amerigroup.com/washington-provider/resources/training-academy**, and go digital with Amerigroup.

** Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup Washington, Inc.*

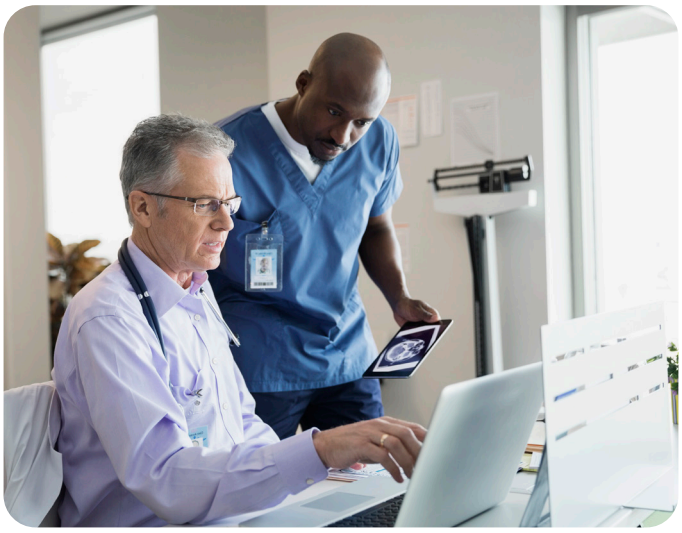
WA-NL-0457-20

Provider transparency update

A key goal of the provider transparency initiatives of Amerigroup Washington, Inc. is to improve quality while managing health care costs.

One of the ways this is accomplished is through our value-based programs (for example, the Provider Quality Incentive Program, the Provider Quality Incentive Program Essentials, Risk and Shared Savings, etc.), known as the Programs.

Value-Based Program Providers (also known as Payment Innovation Providers) in our various value-based programs receive quality, utilization and/or cost data, reports and information about other health care providers (Referral Providers). The Value-Based Program Providers can use that information in selecting Referral Providers for their patients covered under the Programs. If a Referral Provider is higher quality and/or lower cost, this component of the Programs should result in the provider getting more referrals from Value-Based Program Providers. If Referral Providers are lower quality and/or higher cost, the converse should be true.



Providing this type of data, including comparative cost information, to Value-Based Program Providers helps them make more informed decisions about managing health care costs, and maintaining and improving quality of care. It also helps them succeed under the terms of the Programs.

Amerigroup will share data on which we relied in making these quality/cost/utilization evaluations upon request and will discuss it with Referral Providers, including any opportunities for improvement. If you have questions or need support, please refer to your local market representative or care consultant.

WA-NL-0451-20

CAHPS education for providers

Consumer Assessment of Healthcare Providers and Systems (CAHPS)® is an annual standardized survey conducted to assess consumer experience with their health care services and health plan. Providers and their staff play a key role in the member experience. Several questions specific to the member's experience with their provider are included in the CAHPS survey. Education about the CAHPS survey, the importance of focusing on the patient experience and ways to improve the patient experience are included in the *Provider Orientation* and available by visiting **https://providers.amerigroup.com/WA** > Resources > Training Academy.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

WA-NL-0444-20

Important reminder – coding requirements for reimbursement for early elective deliveries

Amerigroup Washington, Inc. appreciates the recent improvements seen in early elective delivery (EED) rates across the country. These improvements have been brought about through the collaborative efforts of state Medicaid agencies, the March of Dimes, CMS, the Joint Commission, the American College of Obstetricians and Gynecologists (ACOG), and many others. The implementation of hospital hard stop policies describing the review of clinical indications and scheduling approval for EED has also increased awareness of the harm that can be caused by non-medically necessary EED and encouraged discussion on the topic between patients, their care providers and hospitals. Voluntary efforts combined with payment reform have been found to further decrease EED rates while increasing gestational age and birth weight for the covered population.[1]

Early elective delivery is defined as a delivery by induction of labor without medical necessity followed by vaginal or caesarean section delivery or a delivery by caesarean section before 39 weeks gestation without medical necessity. Vaginal or caesarean delivery following non-induced labor is not considered an early elective delivery regardless of gestational weeks.

What does this mean for providers?

To improve birth outcomes for our members and further reduce EED, Amerigroup requires a Z3A code indicating gestational age, the appropriate code to indicate the outcome of delivery and supporting medical necessity diagnosis codes on all professional delivery claims for all EED. Amerigroup will apply Milliman Care Guidelines, which defines medically necessary criteria for EED.

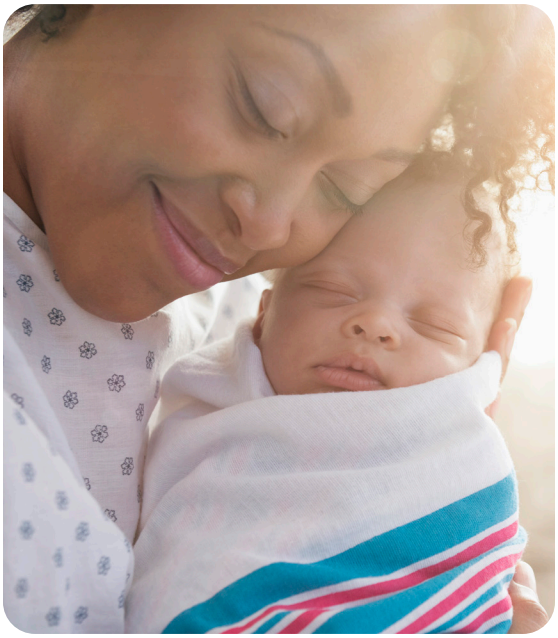
All professional delivery claims (59400, 59409, 59410, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622) with dates of service January 1, 2018, or after, will require a Z3A code indicating gestational age at the time of delivery. If the code is not present on the claim, the claim will deny with the explanation code e02: **Delivery diagnoses incomplete without report of pregnancy weeks of gestation.** You may resubmit the claim with the appropriate Z3A code.

- Professional delivery claims with dates of service January 1, 2018, or after, with gestational age dates of 37 and 38 weeks will require a supporting medically necessary diagnosis code for the early delivery.
- If a professional delivery claim is submitted without evidence of medical necessity for the early delivery, the claim will deny with code k34: **Delivery is not medically indicated**. You may resubmit the claim with the appropriate supporting diagnosis code or appeal with medical records.

1 Dahlen, Heather M., J. Mac Mccullough, Angela R. Fertig, Bryan E. Dowd, and William J. Riley. *Texas Medicaid Payment Reform: Fewer Early Elective Deliveries and Increased Gestational Age And Birthweight.* Health Affairs 36.3 (2017): 460-67. Print

WA-NL-0454-20

Women, Infants, and Children program awareness



Amerigroup Washington, Inc. is working to improve the health outcomes of women and children by promoting Women, Infants, and Children (WIC), the federally funded public health prevention program. The WIC program works to reduce low birth weight, improve immunization rates and **promote breastfeeding** by providing health screenings, nutrition education, **nutrient-rich foods**, breastfeeding support, referrals, and other health and social services. WIC is available for eligible pregnant women, new mothers, infants and children under the age of 5.

We have added comprehensive WIC information to the provider website including handouts, resources and links. You can visit **https://provider.amerigroup.com** to download and share WIC materials with the families you serve. You can also use the website to determine which members are eligible for WIC or find nearby WIC clinics.

WA-NL-0455-20

Medical drug *Clinical Criteria* updates

June 2020 update

On February 21, 2020, May 15, 2020, and June 18, 2020, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the medical drug benefit for Amerigroup Washington, Inc. These policies were developed, revised or reviewed to support clinical coding edits.

Effective dates are reflected in the **Clinical Criteria web posting**.

WA-NL-0445-20

The *Clinical Criteria* is publicly available on our **provider website**. Visit ***Clinical Criteria*** to search for specific policies.

Please submit your questions to **email**.

Transition to AIM Specialty Health *Small Joint Guidelines*

Effective December 1, 2020, Amerigroup Washington, Inc. will transition the clinical criteria for medical necessity review of CG-SURG-74 Total Ankle Replacement services to AIM Specialty Health® (AIM)* small joint guidelines. These reviews will continue to be completed by the Amerigroup Utilization Management team.

You may access and download a copy of the AIM *Small Joint Guidelines* **here**.

** AIM Specialty Health is an independent company providing some utilization review services on behalf of Amerigroup Washington, Inc.*

WA-NL-0449-20

Coding spotlight: tips and best practices for compliance

Need for coding compliance

Coding compliance refers to the process of ensuring that the coding of diagnosis, procedures and data complies with all coding rules, laws and guidelines.

All provider offices and health care facilities should have a compliance plan. Internal controls in the reimbursement, coding, and payment areas of claims and billing operations are often the source of fraud and abuse, and have been the focus of government regulations.

Compliance plan benefits:

- More accurate payment of claims
- Fewer billing mistakes
- Improved documentation and more accurate coding
- Less chance of violating state and federal requirements including self-referral and anti-kickback statutes

Compliance programs can show the provider practice is making an effort to submit claims appropriately and send a signal to employees that compliance is a priority.

Read more online.

WA-NL-0446-20

Claim submissions must include a taxonomy code

The Washington State Health Care Authority requires Apple Health providers to use a preassigned, 10-digit, alphanumeric taxonomy code on all claims. A new contract requirement implemented January 1, 2018, prevents Amerigroup Washington, Inc. from altering claims by adding missing taxonomy codes on the provider's behalf.

What this means to you

Any provider claims submitted to Amerigroup without the appropriate taxonomy codes for the billing, servicing and service location (if applicable) will be rejected.

Provider billing information

Providers should select the taxonomy code that best describes the service rendered to the enrollee and is within the scope of their licensure.

WAPEC-2520-20

New digital provider enrollment tool added to Availity for Washington

In November 2020, Amerigroup Washington, Inc. added new functionality to the Washington provider enrollment tool hosted on the Availity* Portal to further automate and improve your online enrollment experience.

Who can use this new tool?

Professional providers whose organizations do not have a credentialing delegation agreement with Amerigroup may use this new tool.

Providers who submit via roster or have delegated agreements will continue to use the process in place.

What does the tool provide?

- The ability to add new providers to an already existing group
- The ability to apply and request a contract. After review, a contract can be sent back to you digitally for an electronic signature. This eliminates the need for paper applications or paper contracts.
  - Enroll a new group of providers
  - Enroll as an individual/solo provider
  - Add a provider to an already existing group
- A dashboard for real time status on the submitted applications
- Streamlined, complete data submission

How the online enrollment application works

The system automatically accesses CAQH® to pull in all updated information you've already included in your CAQH application. The CAQH information automatically populates the information Amerigroup needs to complete the enrollment process – including credentialing and loading your new provider to our database. Please ensure that your provider information on CAQH is updated and is in a complete or reattested status.

The Availity online application will guide you throughout the enrollment process, providing status updates using a dashboard. As a result, you know where each provider is in the process without having to call or email for a status.

Please note: For any changes to your practice profile and demographics, continue to use the new online provider maintenance form that allows you to electronically submit to Amerigroup any changes to your practice profile and demographics. Availity administrators and assistant administrators can access the form on Availity > Payer Spaces > Resources.

Accessing the enrollment application

Log on to the Availity Portal and select Payer Spaces > Amerigroup Washington, Inc. > Applications > Provider Enrollment to begin the enrollment process.

If your organization is not currently registered for the Availity Portal, the person in your organization designated as the Availity administrator should go to **Availity** and select **Register**.

For organizations already using the Availity Portal, your organization's Availity administrator should go to **My Account Dashboard** from the Availity homepage to register new users and update or unlock accounts for existing users. Staff who need access to the provider enrollment tool need to be granted the role of provider enrollment.

Availity administrators and user administrators will automatically be granted access to provider enrollment.

If you are using Availity today and need access to provider enrollment, work with your organization's administrator to update your Availity role. To determine who your administrator is, you can go to My Account Dashboard > My Administrators.

Need assistance with registering?

Contact Availity Client Services at **1-800-AVAILITY (1-800-282-4548)**.

* Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup Washington, Inc.

WA-NL-0435-20

Inhaled nitric oxide reviews for diagnosis-related group admissions

This is a notification regarding inhaled nitric oxide.

The purpose of this notification is to inform participating hospitals that the use of inhaled nitric oxide (iNO) during an inpatient stay will be reviewed for medical necessity using our *Clinical Utilization Management (UM) Guideline* for Inhaled Nitric Oxide, CG-MED-69. iNO is a covered service for eligible members when the use of iNO meets medical necessity criteria. To view the *Clinical UM Guideline* for INO, visit **https://providers.amerigroup.com/WA.**

This also requires that the facility notify Amerigroup Washington, Inc. of the use of iNO during the course of an inpatient review, and it must be reviewed and approved at some point prior to discharge to avoid exclusion of charges for iNO from the claim payment. If we are not alerted to the use of iNO and, therefore, medical necessity cannot be determined, and charges for iNO are included in the claim submission, the charges for iNO will not be considered in calculation of reimbursement for the stay.

When iNO is used, providers are required to submit an itemized list of charges with the claim for the inpatient stay.

Impact on the diagnosis-related group (DRG) payment

The charges for iNO that are determined to be not medically necessary will not be considered and could impact the DRG outlier payment, as the stay may not reach outlier status as soon as it would with inclusion of these charges. If the case reaches the outlier threshold, we will adjudicate the claim consistent with the financial terms of the contract for outliers, without inclusion of charges for iNO that are not medically necessary or the use of which was not disclosed.

Providers should direct questions regarding this guideline or in relation to the Utilization Management review process to the health plan numbers at **1-800-454-3730**.

Providers should fax new prior authorization requests for physical health inpatient services to **1-800-964-3627**.

Fax submissions of clinical documentation as requested by the Amerigroup Inpatient Utilization Management department supporting medical necessity reviews for inpatient concurrent reviews to **1-855-225-9940**.

WA-NL-0448-20

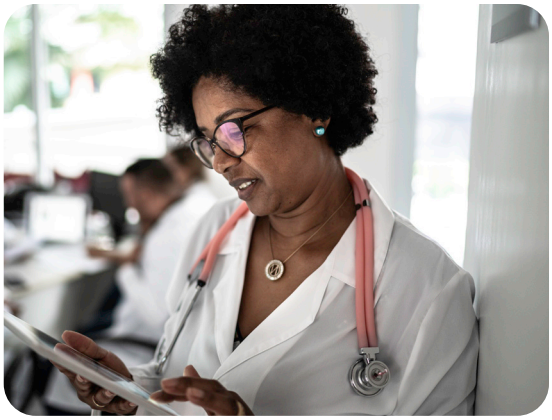
Attention: updated laboratory fee schedule

Effective January 1, 2021, Amerigroup Washington, Inc. will update the *Reference Laboratory Fee Schedule* for Amerigroup. This change is applicable to providers who are reimbursed, either in whole or in part, based on the fee schedule for laboratory services for Medicaid.

The actual impact to any particular provider will depend on the codes most frequently billed by that provider.

The updated fee schedule will be available on the **Availity Portal*** on the effective date of January 1, 2021.

WA-NL-0396-20



Prior authorization requirements

Effective December 1, 2020, prior authorization (PA) requirements will change for HCPCS code 55899. This will be reviewed using MED.00132: Adipose-derived Regenerative Cell Therapy and Soft Tissue Augmentation Procedures. This code will require PA by Amerigroup Washington, Inc. for members.

PA requirements will be added to the following:

- 55899 — Unlisted procedure, male genital system

WA-NL-0442-20

Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions take precedence over these PA rules and must be considered first when determining coverage. **Noncompliance with new requirements may result in denied claims.**

To request PA, you may use one of the following methods:

- Web: **https://www.availity.com**
- Fax: **1-800-964-3627**
- Phone: **1-800-454-3730**

Not all PA requirements are listed here. PA requirements are available to contracted providers by accessing the Provider Self-Service Tool at **https://www.availity.com** or at **https://provider.amerigroup.com/WA** > Login. Contracted and noncontracted providers who are unable to access Availity* may call Provider Services at **1-800-454-3730** for assistance with PA requirements.

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COVID-19 information from Amerigroup Washington, Inc.

View the **article** in the Medicaid section.

WAPEC-2237-20

Claim submissions must include a taxonomy code

View the **article** in the Medicaid section.

WAPEC-2520-20

Digital transactions cut administrative tasks in half

View the **article** in the Medicaid section.

WA-NL-0457-20/AGPCRNL-0139-20

Attention: updated laboratory fee schedule

View the **article** in the Medicaid section.

WA-NL-0396-20/AGPCRNL-0104-20

Medical drug *Clinical Criteria* updates

June 2020 update

On February 21, 2020, May 15, 2020, and June 18, 2020, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the medical drug benefit for Amerigroup Washington, Inc. These policies were developed, revised or reviewed to support clinical coding edits.

Effective dates are reflected in the **Clinical Criteria web posting**.

AGPCRNL-0133-20

The *Clinical Criteria* is publicly available on our **provider website**. Visit **Clinical Criteria** to search for specific policies.

Please submit your questions to **email**.

FDA approvals and expedited pathways used — new molecular entities

Amerigroup Washington, Inc. reviews the activities of the FDA's approval of drugs and biologics on a regular basis to understand the potential effects for both our providers and members.

The FDA approves new drugs/biologics using various pathways of approval. Recent studies on the effectiveness of drugs/biologics going through these different FDA pathways illustrates the importance of clinicians being aware of the clinical data behind a drug or biologic approval in making informed decisions.

Approval pathways the FDA uses for drugs/biologics	
Standard Review	The Standard Review process follows well-established paths to make sure drugs/biologics are safe and effective when they reach the public. From concept to approval and beyond, FDA performs these steps: reviews research data and information about drugs and biologics before they become available to the public, watches for problems once drugs and biologics are available to the public, monitors drug/biologic information and advertising, and protects drug/biologic quality. **To learn more about the Standard Review process, go here.**
Fast Track	Fast Track is a process designed to facilitate the development and expedite the review of drugs/biologics to treat serious conditions and fill an unmet medical need. **To learn more about the Fast Track process, go here.**
Priority Review	A Priority Review designation means FDA's goal is to take action on an application within six months. **To learn more about the Priority Review process, go here.**
Breakthrough Therapy	A process designed to expedite the development and review of drugs/biologics that may demonstrate substantial improvement over available therapy. **To learn more about the Breakthrough Therapy process, click here.**
Orphan Review	Orphan Review is the evaluation and development of drugs/biologics that demonstrate promise for the diagnosis and/or treatment of rare diseases or conditions. **To learn more about the Orphan Review process, click here.**
Accelerated Approval	These regulations allowed drugs/biologics for serious conditions that filled an unmet medical need to be approved based on a surrogate endpoint. **To learn more about the Accelerated Approval process, click here.**

New molecular entities approvals — January to August 2020

Certain drugs/biologics are classified as new molecular entities (NMEs) for purposes of FDA review. Many of these products contain active ingredients that have not been approved by FDA previously, either as a single ingredient drug or as part of a combination product; these products frequently provide important new therapies for patients.

Amerigroup reviews the FDA-approved NMEs on a regular basis. To facilitate the decision-making process, we are providing a list of NMEs approved from January to August 2020, along with the FDA approval pathway utilized.

Read more online.

AGPCRNL-0138-20

AIM Specialty Health Musculoskeletal program expansion update

As previously communicated, AIM Specialty Health® (AIM),* planned to expand their Musculoskeletal program to perform medical necessity reviews for certain elective surgeries of the small joint for Medicare Advantage members. However, this expansion has been postponed until further notice.

If you have questions related to guidelines, contact AIM via email at aim.guidelines@aimspecialtyhealth.com.

AGPCRNL-0134-20

Transition to AIM Specialty Health *Rehabilitative Service Clinical Appropriateness Guidelines*

Amerigroup Washington, Inc. previously communicated that AIM Specialty Health®(AIM)* would transition the *Clinical Criteria* for Medical Necessity Review of Certain Rehabilitative Services to AIM *Rehabilitative Service Clinical Appropriateness Guidelines* as part of the AIM Rehabilitation Program beginning October 1, 2020. Please be aware that this transition has been delayed. **The new transition date will be in December 1, 2020.**

AGPCRNL-0136-20

** AIM Specialty Health is an independent company providing some utilization review services on behalf of Amerigroup Washington, Inc.*

Policy Reminder — Medicaid
Nurse Practitioner and Physician Assistant Services, Professional
(Effective 04/24/20)

This article is to inform you that there is now a separate and specific professional reimbursement policy to reference for Nurse Practitioner and Physician Assistant Services.

Amerigroup Washington, Inc. continues to allow reimbursement for services provided by nurse practitioner (NP) and physician assistant (PA) providers. Unless provider, state, federal or CMS contracts and/or requirements indicate otherwise, reimbursement is based upon all of the following:

- Service is considered a physician's service
- Service is within the scope of practice
- A payment reduction consistent with CMS

Services furnished by the NP or PA should be submitted with their own NPI.

For additional information on the Nurse Practitioner and Physician Assistant Services Professional policy, visit **https://providers.amerigroup.com**. Under Claims, select Reimbursement Policies > Medicaid Policies.

WA-NL-0440-20

Policy Update — Medicare Advantage
Nurse Practitioner and Physician Assistant Services, Professional
(Effective 04/24/20)

This update is to inform you that there is now a separate and specific professional reimbursement policy to reference for Nurse Practitioner and Physician Assistant Services.

Amerigroup Washington, Inc. continues to allow reimbursement for services provided by nurse practitioner (NP) and physician assistant (PA) providers. Unless provider, state, federal or CMS contracts and/or requirements indicate otherwise, reimbursement is based upon all of the following:

- Service is considered a physician's service
- Service is within the scope of practice
- A payment reduction consistent with CMS

Services furnished by the NP or PA should be submitted with their own NPI.

For additional information, please review the Nurse Practitioner and Physician Assistant Services professional reimbursement policy at **https://providers.amerigroup.com**. Under Quick Tools, select Reimbursement Policies > Medicare.

AGPCRNL-0129-20

Policy Update — Medicare Advantage
Emergency Department: Leveling of Evaluation and Management Services

Effective January 15, 2021, Amerigroup Washington, Inc. classifies with an Evaluation and Management (E&M) code level the intensity/complexity of emergency department (ED) interventions a facility uses to furnish all services indicated on the claim. E&M services will be reimbursed based on this classification. Facilities must use appropriate *HIPAA* compliant codes for all services rendered during the ED encounter. If the E&M code level submitted is higher than the E&M code level supported on the claim, we reserve the right to perform one of the following:

- Deny the claim and request resubmission at the appropriate level or request the provider submit documentation supporting the level billed.
- Adjust reimbursement to reflect the lower ED E&M classification.
- Recover and/or recoup monies previously paid on the claim in excess of the E&M code level supported.

Providers who believe their medical record documentation supports reimbursement for the originally submitted level for the E&M service will be able to follow the dispute resolution process in accordance with the terms of their contract. Claims disputes require a statement providing the reason the intensity/complexity would require a different level of reimbursement and the medical records, which should clearly document the facility interventions performed and referenced in that statement.

For additional information, please review the Emergency Department: Leveling of Evaluation and Management Services reimbursement policy at **https://providers.amerigroup.com**. Under Quick Tools, select Reimbursement Policies > Medicaid.

AGPCARE-0623-20